OLR RESEARCH REPORT

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OLR BACKGROUNDER: STATE-MANDATED HEALTH INSURANCE BENEFITS

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This report lists and briefly describes Connecticut's mandated health insurance benefits. It updates an earlier report (2011-R-0504) by incorporating revisions enacted in 2012. (See OLR Report 2008-R-0138 for a list of health care providers and facilities whose services health insurance policies must cover under Connecticut law.)

SUMMARY

A health insurance "mandate" is a requirement that an insurance company or health plan cover a specified benefit. In Connecticut, private health insurance benefit mandates are contained in Chapter 700c of the general statutes.

Each benefit mandate statute identifies the specific plans to which the mandate applies. Many of the mandates apply to both individual and group health insurance plans, including those insured plans issued to small employer groups. However, due to the federal Employee Retirement Income Security Act (ERISA), state benefit mandates generally do not apply to self-funded plans. For more information about this ERISA preemption, see OLR Report 2005-R-0753.

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In 2012, the legislature enacted the following laws related to Connecticut's health insurance mandates:

1. PA 12-44, An Act Concerning Insurance Coverage for the Birth-to-Three Program (effective July 1, 2012);

2. PA 12-61, An Act Concerning Guidelines for Health Insurance Coverage for Colorectal Cancer Screening (effective January 1, 2013);

3. PA 12-150, An Act Concerning Guidelines for Health Insurance Coverage for Breast Magnetic Resonance Imaging (effective upon passage, June 15, 2012); and

4. PA 12-190, An Act Concerning Deductibles for Screening Colonoscopies and Screening Sigmoidoscopies (effective January 1, 2013).

CONNECTICUT'S MANDATED HEALTH INSURANCE BENEFITS

Table 1 lists and briefly describes Connecticut's mandated health insurance benefits. It also provides the statutory citation and indicates whether the mandate applies to individual health insurance plans, group health insurance plans, or both.

Table 1: Connecticut's Mandated Health Insurance Benefits*

CGS §	*Mandate*	*Group, Individual, or Both*	*Description*
38a-476(b)(1)	Preexisting Condition Coverage	Group	May not impose preexisting condition exclusion beyond 12 months after effective date of coverage, and exclusion may relate only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received six months before the policy's effective date.
38a-476(b)(2)	Preexisting Condition Coverage	Individual, except for short-term policy	May not impose preexisting condition exclusion beyond 12 months after effective date of coverage, and exclusion may relate only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received 12 months before the policy's effective date.
38a-476(g)	Preexisting Condition Coverage	Individual short-term policy	May not impose preexisting condition exclusion beyond 12 months after effective date of coverage, and exclusion may relate only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received 24 months before the policy's effective date.
38a-476b	Availability of Psychotropic Drugs	Both	No mental health care benefit provided under state law, with state funds, or to state employees may limit the availability of the most effective psychotropic drugs.
38a-483c 38a-513b	Experimental Treatments	Both	Procedures, treatments, or drugs that have completed a Phase III Food and Drug Administration clinical trial. Appeals process expedited for those with a life expectancy of less than two years.

Table 1 (continued)

CGS §	Mandate	Group, Individual, or Both	Description
38a-488a 38a-514	Mental Illness	Both	Diagnosis and treatment of mental or nervous conditions. Coverage cannot differ from the terms, conditions, or benefits for the diagnosis or treatment of medical, surgical, or other physical health conditions. Requires a policy to cover a residential treatment facility when a physician, psychiatrist, psychologist, or clinical social worker assesses the person and determines that he or she cannot appropriately, safely, or effectively be treated in another setting.
38a-514b	Autism Spectrum Disorders	Group	Policies must cover the diagnosis and treatment of autism spectrum disorders, including (1) behavioral therapy for a child age 14 or younger and (2) certain prescription drugs and psychiatric and psychological services. A policy can limit coverage for behavioral therapy to $50,000 a year for a child age eight or younger, $35,000 for a child age nine to 12, and $25,000 for a 13-or 14-year-old.
38a-482 38a-497	Children to Age 26	Both	Coverage continues at least until the policy anniversary date on or after the date the child (1) gets coverage under his or her employer's group health plan or (2) turns age 26.
38a-489 38a-515 38a-554	Children - Mentally or Physically Handicapped	Both	After passing dependent status age when coverage would otherwise end, coverage must continue if child is both mentally or physically handicapped and dependent upon insured for support.
38a-490 38a-508 38a-516 38a-549	Children - Newborns and Adopted	Both	Injury and sickness, including care and treatment of congenital defects and birth abnormalities, for newborns from birth and for adopted children from legal placement for adoption. Newborns are covered for 61 days. To extend coverage, notification and premium payment must be given to the insurer.
38a-497 38a-554	Stepchildren	Both	Policies must cover stepchildren on the same basis as biological children.
38a-490a As amended by PA 12-44	Birth-to-Three Services	Individual	At least $6,400 per child annually for medically necessary early invention services, up to $19,200 per child over three years. Policies cannot impose coinsurance, copayments, deductibles, or other out-of-pocket expenses for these services, unless the plan is a high deductible health plan used to establish a medical savings account.
38a-516a As amended by PA 12-44	Birth-to-Three Services	Group	At least $6,400 per child annually for medically necessary early invention services, up to $19,200 per child over three years. Coverage for children with autism spectrum disorders must be at least $50,000 per child annually, up to $150,000 per child over three years. Policies cannot impose coinsurance, copayments, deductibles, or other out-of-pocket expenses for these services, unless a high deductible health plan used to establish a medical savings account.
38a-490b 38a-516b	Children's Hearing Aids	Both	Hearing aids for children age 12 and under. Coverage may be limited to $1,000 within a 24-month period.
38a-490c 38a-516c	Craniofacial Disorders	Both	Medically necessary orthodontic processes and appliances for treatment of craniofacial disorders for people age 18 or younger. Coverage is not required for cosmetic surgery.
38a-492l 38a-516d	Children with Cancer	Both	Coverage for children diagnosed with cancer after December 31, 1999 for neuropsychological testing a physician orders to assess the extent chemotherapy or radiation treatment has caused the child to have cognitive or developmental delays. Insurers cannot require pre-authorization for the tests.
38a-491a 38a-517a	Dental Coverage	Both	Medically necessary general anesthesia, nursing, and related hospital services for in-patient, outpatient, or one-day dental services.

Table 1 (continued)

CGS §	Mandate	Group, Individual, or Both	Description
38a-492 38a-518	Accidental Ingestion or Consumption of Controlled Drugs	Both	Emergency medical care for the accidental ingestion or consumption of controlled drugs. Coverage is subject to a minimum of 30 days inpatient care and a maximum $500 for outpatient care per calendar year.
38a-492a 38a-518a	Hypodermic Needles and Syringes	Both	Hypodermic needles and syringes prescribed by a practitioner for administering medications.
38a-492b 38a-518b	Off-Label Cancer Drugs	Both	If a prescription drug is recognized for treatment of a specific type of cancer, a policy cannot exclude coverage of the drug when it is used for another type of cancer.
38a-492c 38a-518c	Protein Modified Food and Specialized Formula	Both	Amino acid modified and low protein modified food products when prescribed for the treatment of inherited metabolic diseases and cystic fibrosis. Medically necessary specialized formula for children up to age 12. Food and formula must be administered under the direction of a physician. Coverage for preparations, food products, and formulas must be on the same basis as coverage for outpatient prescription drugs.
38a-492d 38a-518d	Diabetes	Both	Laboratory and diagnostic tests for all types of diabetes. Medically necessary equipment, drugs, and supplies for insulin-dependent, insulin using, gestational, and non-insulin using diabetes.
38a-492e 38a-518e	Diabetes Self-Management Training	Both	Outpatient self-management training prescribed by a licensed health care professional. Coverage is subject to the same terms and conditions as other policy benefits.
38a-492f 38a-518f	Prescription Drugs Removed from Formulary	Both	A prescription drug that has been removed from the list of covered drugs must be continued if the insured was previously using the drug for the treatment of a chronic illness and it is deemed medically necessary.
38a-492g 38a-518g	Prostate Screening	Both	Laboratory and diagnostic tests to screen for prostate cancer for men who are symptomatic, have a family history, or are over 50. Policy must cover medically necessary prostate cancer treatment in accordance with guidelines established by the National Comprehensive Cancer Network, American Cancer Society, or American Society of Clinical Oncology.
38a-492h 38a-518h	Lyme Disease Treatment	Both	Lyme disease treatment including not less than 30 days of intravenous antibiotic therapy, 60 days of oral antibiotic therapy, or both, and further treatment if recommended by a rheumatologist, infectious disease specialist, or neurologist.
38a-492i 38a-518i	Pain Management	Both	Access to a pain management specialist and coverage for pain treatment ordered by such specialist. Cannot require an insured person to use an alternative brand name prescription or over-the-counter drug before using a brand name prescription drug prescribed by a licensed physician for pain management.
38a-492j 38a-518j	Ostomy Appliances and Supplies	Both	If policy covers ostomy surgery, it must also cover medically necessary ostomy-related appliances and supplies, up to $2,500 per year.
38a-492k 38a-518k As amended by PA 12-61 and PA 12-190	Colorectal Cancer Screening	Both	Colorectal cancer screening. Frequency of screening must be based on recommendations by the American College of Gastroenterology, until December 31, 2012. Effective January 1, 2013, frequency of screening must instead be based on recommendations by the American Cancer Society. Cannot impose coinsurance, copayment, deductible, or other out-of-pocket expense for any additional colonoscopy a physician orders for an insured person in a policy year, unless a high deductible insurance plan used to establish a medical savings account. Effective January 1, 2013, cannot impose a deductible for a procedure initially undertaken as a screening colonoscopy or screening sigmoidoscopy.

Table 1 (continued)

CGS §	Mandate	Group, Individual, or Both	Description
38a-492m 38a-518l	Prescription Eye Drops	Both	Policies that provide prescription eye drop coverage cannot deny coverage for prescription renewals when (1) the refill is requested by the insured person less than 30 days from either (a) the date the original prescription was given to the insured or (b) the last date the prescription refill was given to the insured, whichever is later, and (2) the prescribing physician indicates on the original prescription that additional quantities are needed and the refill request does not exceed this amount.
38a-492n 38a-518m	Epidermolysis Bullosa	Both	Policies must cover wound care supplies that are medically necessary to treat epidermolysis bullosa (a rare skin disorder) and administered under a physician's direction.
38a-492o 38a-518o	Bone Marrow Testing	Both	Policies must cover compatibility testing for bone marrow transplants for people who join the National Marrow Donor Program.
38a-493 38a-520	Home Health Care	Both	Home health care, including (1) part-time or intermittent nursing care and home health aide services; (2) physical, occupational, or speech therapy; (3) medical supplies, drugs and medicines; and (4) medical social services. Coverage can be limited to no less than 80 visits per year and, for a terminally ill person, no more than $200 for medical social services. Coverage can be subject to an annual deductible of up to $50 and a coinsurance of no less than 75%, except that a high deductible plan used to establish a medical savings account is exempt from the deductible limit.
38a-523	Comprehensive Rehabilitation Services	Group	Group health insurance must offer coverage for comprehensive rehabilitation services, including (1) physician services, physical and occupational therapy, nursing care, psychological and audiological services, and speech therapy; (2) social services provided by a social worker; (3) respiratory therapy; (4) prescription drugs and medicines; (5) prosthetic and orthotic devices and; (6) other supplies and services prescribed by a doctor.
38a-496 38a-524	Occupational Therapy	Both	If policy covers physical therapy, it must provide coverage for occupational therapy.
38a-498 38a-525	Ambulance Services	Both	Ambulance service when medically necessary. Payment must be on a direct pay basis where notice of assignment is reflected on the bill.
38a-498a 38a-525a	911 Calls	Both	Cannot require preauthorization for 911 calls.
38a-498b 38a-525b	Mobile Field Hospitals	Both	Benefits for isolation care and emergency services provided by mobile field hospitals, previously called critical access hospitals. Such benefits are subject to any policy provisions that apply to other covered services. The rates a policy pays must be equal to the rates Medicaid pays, as determined by the Department of Social Services.
38a-498c 38a-525c	Injured and Under the Influence	Both	Insurance polices prohibited from denying coverage for health care services rendered to an injured insured person if the injury is alleged to have occurred or occurs when the person has an elevated blood alcohol level (0.08% or more) or is under the influence of drugs or alcohol.
38a-501	Long-Term Care Policy – Non-Forfeiture	Individual	Prohibits an insurer from issuing or delivering a long-term care policy on or after July 1, 2008 unless it had offered the prospective insured an optional non-forfeiture benefit during the policy solicitation or application process. If the non-forfeiture option is declined, the insurer must give the insured a contingent benefit upon lapse.
38a-501	Long-Term Care Policy – Elimination Period	Individual	Requires an elimination period (i.e., a waiting period after the onset of the injury, illness, or function loss during which no benefits are payable) that is (1) up to 100 days of confinement or (2) between 100 days and two years of confinement if an irrevocable trust is in place that is estimated to be sufficient to cover the person's confinement costs during this period. Sets requirements for the trust.

Table 1 (continued)

CGS §	Mandate	Group, Individual, or Both	Description
38a-503 38a-530 As amended by PA 12-150	Mammography and Breast Cancer Screening	Both	Baseline mammogram for woman 35 to 39 and one every year for woman 40 and older. Additional coverage must be provided for a comprehensive ultrasound screening of a woman's entire breast(s) if (1) a mammogram shows heterogeneous or dense breast tissue based on BI-RADS or (2) the woman is at increased breast cancer risk because of family history, her prior history, genetic testing, or other indications determined by her physician or advanced-practice nurse. Coverage is subject to any policy provisions applicable to other covered services. Coverage must be provided for magnetic resonance imaging (MRI) in accordance with guidelines established by the American Cancer Society.
38a-503b 38a-530b	Obstetrician-Gynecologist; Pap Smear	Both	Direct access to participating in-network ob-gyn for gynecological examination, pregnancy care, and primary and preventive obstetric and gynecologic services required as result of a gynecological examination or condition (includes pap smear). Female enrollees may also designate participating ob-gyn or other doctor as primary care provider.
38a-503c 38a-530c	Maternity Care	Both	Minimum 48-hour hospital stay for mother and newborn after vaginal delivery and minimum 96-hour hospital stay after caesarian delivery.
38a-503d 38a-530d	Mastectomy	Both	Minimum 48-hour hospital stay after mastectomy or lymph node dissection or longer stay if recommended by physician.
38a-503e 38a-530e	Contraceptives	Both	If prescription drugs are covered, prescription contraceptives must be covered. An employer or individual may decline contraceptive coverage if it conflicts with religious beliefs.
38a-533	Alcoholism	Group	Expenses incurred in connection with medical complications of alcoholism such as cirrhosis of the liver, gastrointestinal bleeding, pneumonia, and delirium tremens.
38a-507 38a-534	Chiropractic Services	Both	Cover chiropractor services to same extent as coverage for a physician.
38a-535	Preventive Pediatric Care	Group	Preventive pediatric care at the following intervals (1) every 2 months from birth to 6 months, (2) every 3 months from 9 to 18 months, and (3) annually from 2 to 6 years of age. Coverage is subject to any policy provisions that apply to other services covered under the policy.
38a-535	Lead Screening	Both	Coverage for blood lead screening and risk assessments ordered by primary care providers in accordance with the law.
38a-509 38a-536	Infertility	Both	Medically necessary costs of diagnosing and treating infertility.
38a-542(a)&(b)	Breast Implant Removal	Group	Medically necessary removal of breast implants implanted on or before July 1, 1994. Annual coverage must be at least $1,000.
38a-504(a)&(b) 38a-542(a)&(b)	Treatment for Leukemia, Tumors, and Wigs for Chemotherapy Patients	Both	Surgical removal of tumors and treatment of leukemia, including outpatient chemotherapy, reconstructive surgery, non-dental prosthesis, surgical removal of breasts due to tumors, and a wig if prescribed by a licensed oncologist for a patient suffering hair loss from chemotherapy. Annual coverage must be at least $500 for surgical tumor removal, $500 for reconstructive surgery, $500 for outpatient chemotherapy, $350 for a wig, and $300 for prosthesis, except for surgical removal of breasts due to tumors, the prosthesis benefit must be at least $300 for each breast removed.
38a-504(c) 38a-542(c)	Breast Reconstruction after Mastectomy	Both	Reconstructive surgery on non-diseased breast for symmetrical appearance. Coverage is subject to the same terms and conditions as other benefits under the policy.
38a-504(d) 38a-542(d)	Oral Chemotherapy	Both	Policies that cover intravenously and orally administered anti-cancer medications must cover the orally administered medication on at least as favorable a basis as the intravenously administered medication.

Table 1 (continued)

CGS §	Mandate	Group, Individual, or Both	Description
38a-504a – 38a-504q; 38a-542a – 38a-542q	Cancer and Other Clinical Trials	Both	Routine patient costs relating to cancer clinical trials and disabling or life-threatening chronic diseases. Out-of-network hospitalization paid as in-network benefit if services are not available in network. Such trials must have peer-reviewed protocols approved by one of several federal organizations.
38a-511 38a-550	Copays for Imaging Services (MRIs, CAT scans, and PET scans)	Both	Limits copays for MRIs and CAT scans to (1) $375 for all such services annually and (2) $75 for each one. Limits copays for PET scans to (1) $400 for all such scans annually and (2) $100 for each one. Limits not applicable (1) if the ordering physician performs the service or is in the same practice group as the one who does and (2) to high deductible health plans designed to be compatible with federally qualified Health Savings Accounts.

* Note: Some mandates require that services be "medically necessary." State law specifies the definition of "medically necessary" that policies must include (see CGS §§ 38a-482a and 38a-513c).

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